VI. PREPAYMENT REVIEW OF PROVIDERS

Prepayment review may be implemented based on the results of the off-site review and/or medical record audit. Prepayment Review is implemented for those providers exhibiting a high degree of difficulty with appropriately billing Medicaid Services, sometimes identified to be potentially seeking overpayment. Criteria, unique to each provider, are developed based on the specific aberrant practices and billing patterns that are identified in the review. The Indiana Administrative Code (IAC) does not authorize appeal rights relative to placement on prepayment review, therefore, appeals are not accepted. The Prepayment Review Coordinator will complete all tasks outlined in this section unless otherwise specified.

A. Initiation of Prepayment Review

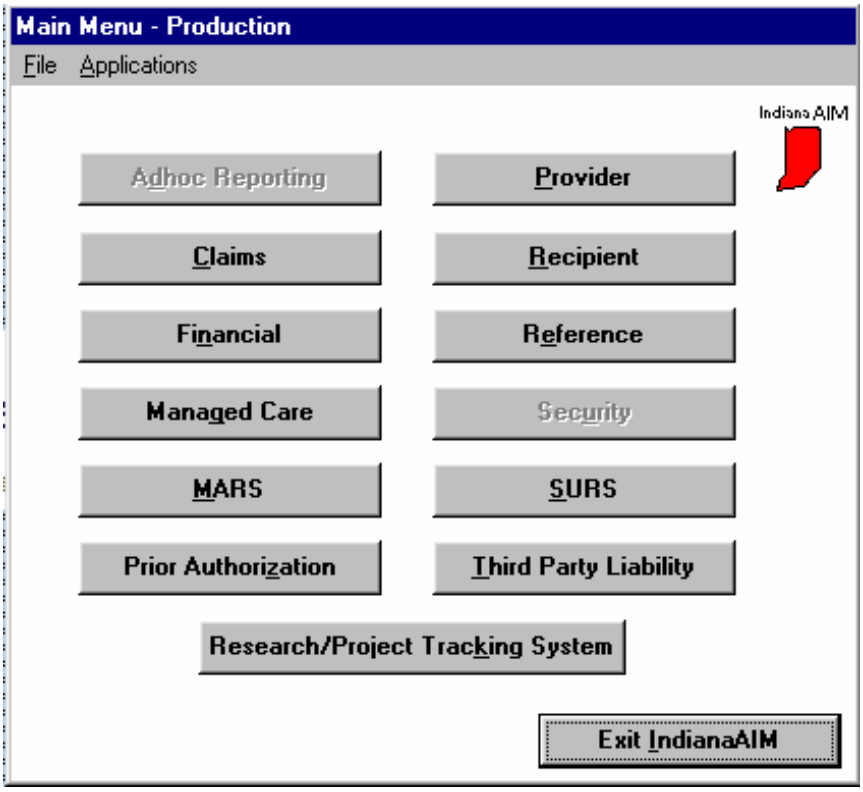
1. Recommendation

   A provider may be recommended for placement on prepayment review based on the findings of a referral, offsite review, and/or provider audit. In addition, OMPP may also request that a provider be placed on prepayment review. The SUR Reviewer assigned to the case presents the prepayment review recommendation to the Audit Supervisor, SUR Director, Program Director and Medical Director for approval. When the recommendation is approved, the SUR Reviewer will incorporate the prepayment review notification into the findings letter, if applicable. If a provider findings letter will not be sent, notification of prepayment review will occur through the Notification of Prepayment Review letter See **Exhibit VI – 1**. In both of the above cases, the provider will also be sent the Prepayment Review Criteria form See **Exhibit VI – 2**. This letter should be signed and returned by the provider. This letter will list all codes subject to prepayment review along with an effective date. The SUR Reviewer will coordinate with the Prepayment Review Coordinator to determine the effective date.

2. Updating Provider Restriction in Indiana*AIM*

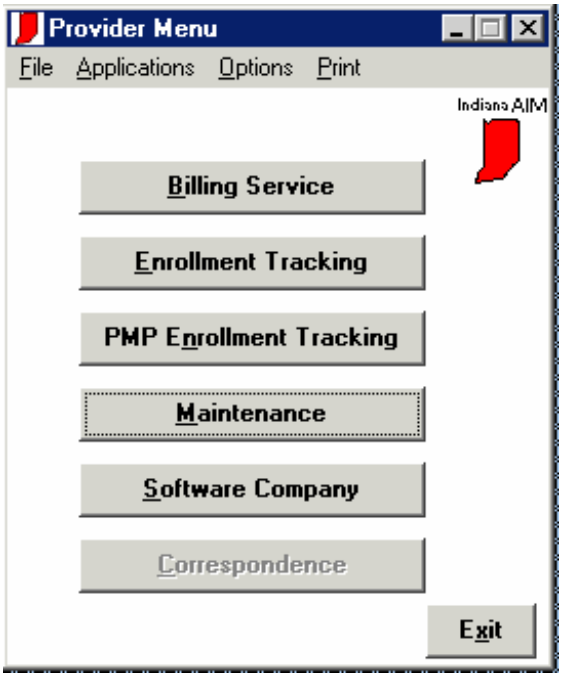
   The following steps are completed to appropriately restrict a provider to prepayment review.

FIGURE VI – 1
MAIN MENU



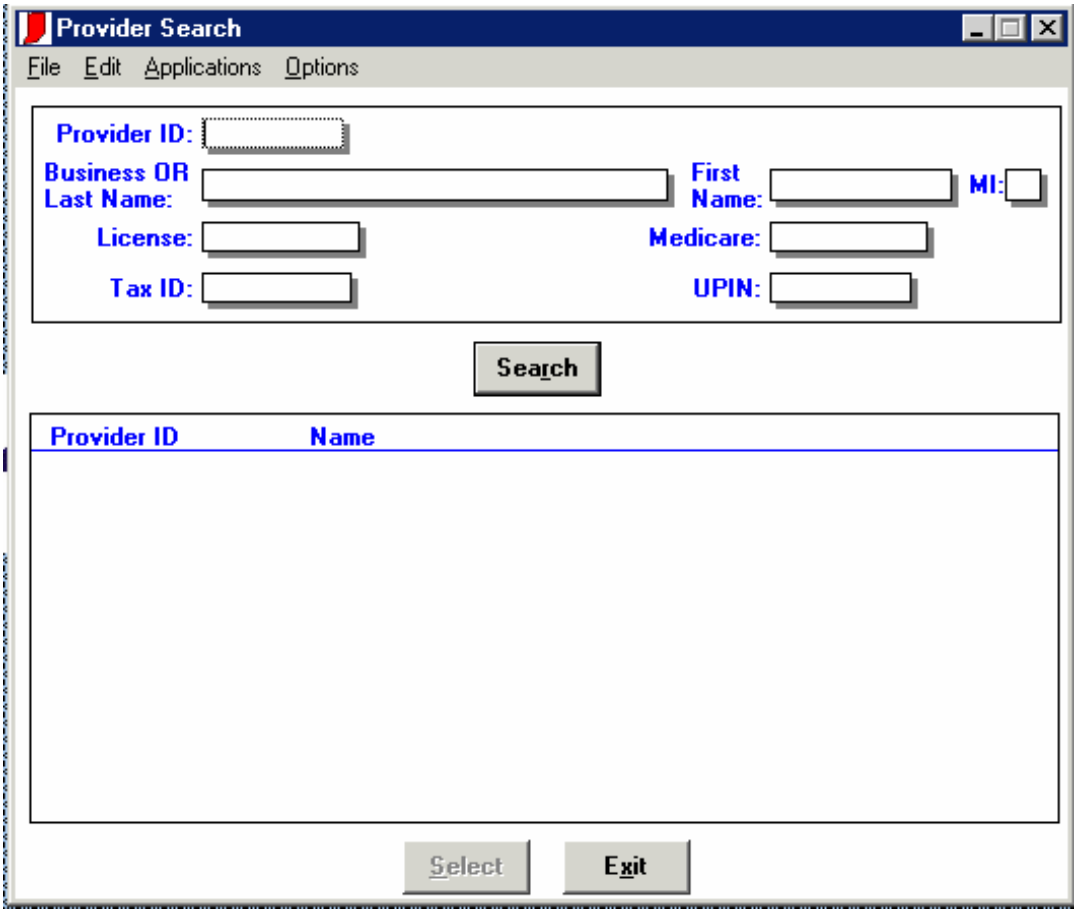
a. Select Provider to begin provider restriction.

FIGURE VI – 2
PROVIDER MENU



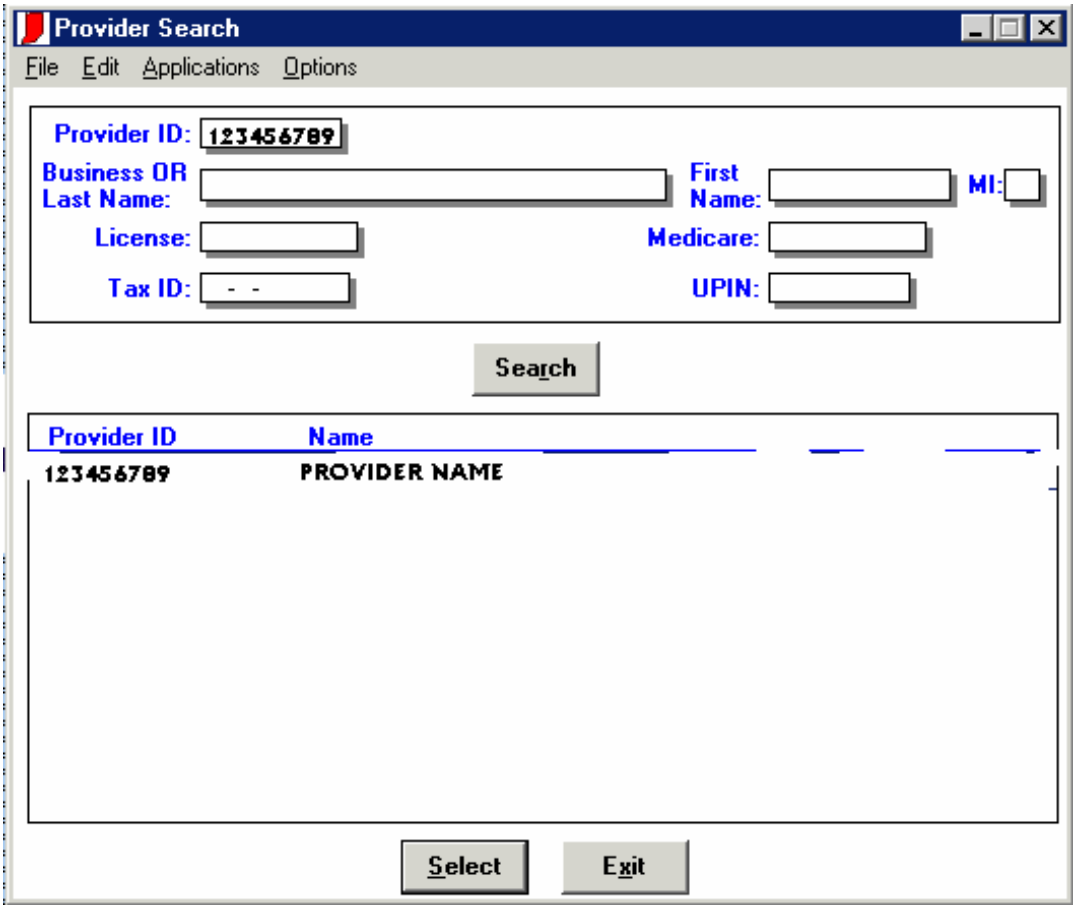
b. Choose Maintenance to select the provider for restriction.

FIGURE VI – 3
PROVIDER SEARCH



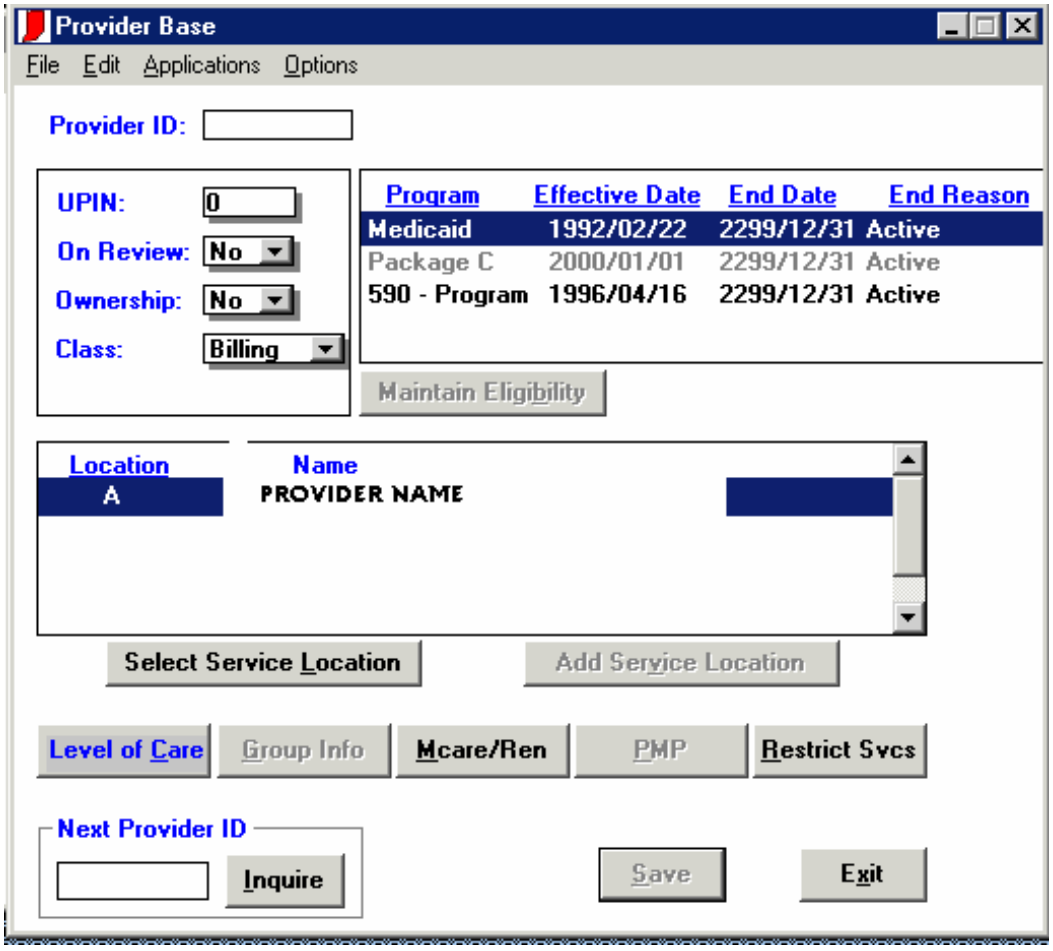
c. Enter the provider number recommended for restriction.

FIGURE VI – 4
PROVIDER SEARCH



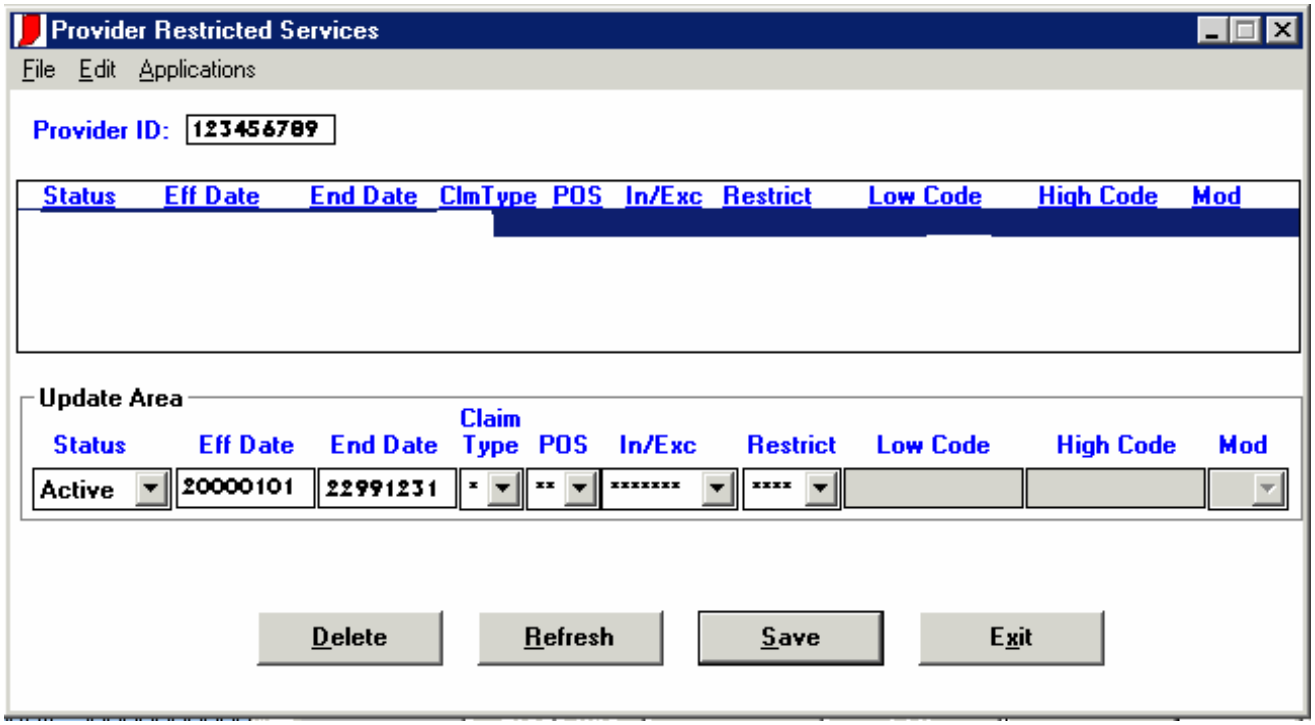
d. Verify provider information.
e. Choose Select.

FIGURE VI – 5
PROVIDER BASE



f. Select Restrict Svcs.

FIGURE VI – 6
PROVIDER RESTRICTED SERVICES



g. Proceed to the Update Area. Enter the Effective Date. This is the date recommended by the SUR Reviewer for prepayment review initiation. Provider claims from this date forward will begin suspending for prepayment review. This date may differ from the date prepayment review is implemented as this date can be retrospective.

h. Enter the End Date. This date will automatically remain open until a recommendation to remove the provider from prepay status is received. Therefore the date will reflect 22991231.

i. Select a Claim Type from the drop down menu. Providers will have a claim type all (*) unless otherwise specified.

j. Select POS from the drop down menu. Choose all (*).

k. Select In/Exc codes for prepayment review. In almost all cases Include is selected. Exclude may be used, for example, if you remove the provider from prepayment review for specific codes.

l. Select Restrict from drop down menu.
   1. Utilize Drug for NDC codes.
   2. Utilize Proc when restricting procedure codes.
   3. Utilize Rev when restricting revenue codes.

m. If the recommendation is to review only a range of codes, utilize the Low Code data field. Enter the lowest code number for review; subsequently enter the High Code for review.

n. Enter a modifier in the MOD field to specify a modifier with a procedure code only when a range of codes is utilized.
o. Select Save. The restriction information entered in the update area will then appear in the top section of the window.
p. If the first line entered doesn't include all of the restriction recommendations for prepayment review, a second line may be completed. Complete the above steps g through o to enter each subsequent line item.
q. Print the completed screen from Indiana*AIM* once all of the restriction has been completed. This print out is placed in the prepayment review file.
r. Notify the fiscal agent's Provider Enrollment Supervisor to change the On Review field in the Provider Base screen of Indiana*AIM* to Yes.
s. Update the SURS database with the above information.

3. Provider Prepayment Review File

A separate provider case file is maintained for prepayment review. Creation of this file should begin at implementation. The file should contain the following contents.

a. Provider Notification of Prepayment letter
b. Signed copy of the Prepayment Review Criteria form
c. Print out of the Indiana*AIM* restriction screen
d. Correspondence received from the provider
e. Letters sent to the provider by the Prepayment Review Coordinator or any other staff member related to prepayment review
f. A copy of each monthly report sent to the provider
g. All other relevant information

B. Prepayment Review Maintenance and Claim Adjudication

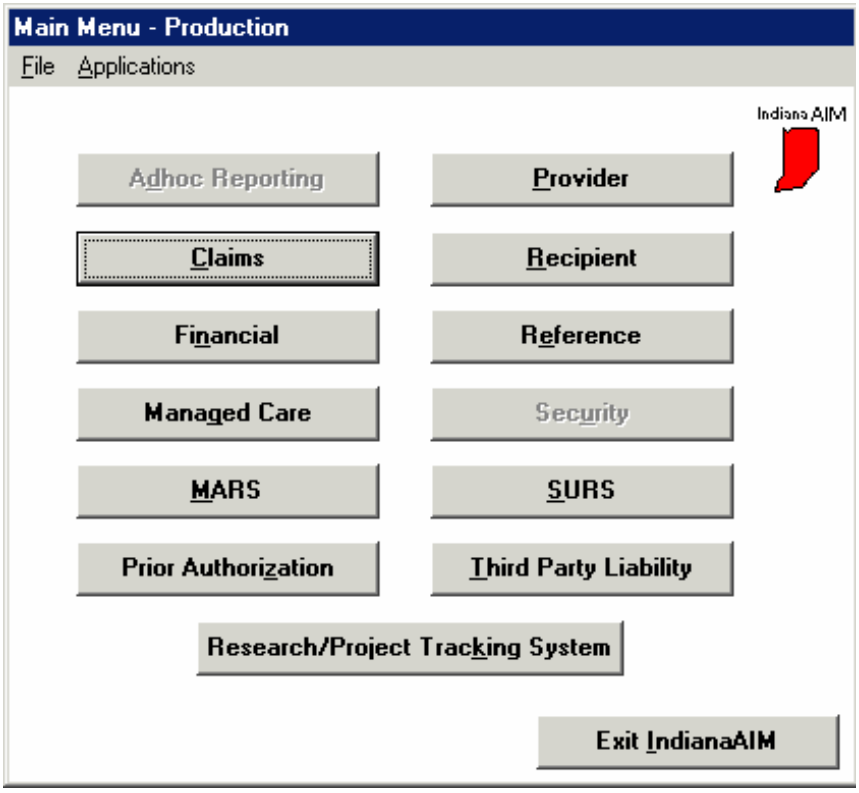
1. Receipt of Claims for Prepayment Review

a. Claims received from the fiscal agent are delivered to the Prepayment Review/Recoupment Support Specialist.
b. The Prepayment Review/Recoupment Support Specialist verifies receipt of claim documentation from the fiscal agent by checking each claim off the list sent by the fiscal agent.
c. The Prepayment Review/Recoupment Support Specialist faxes confirmation of claim receipt to the fiscal agent's Claims Support Specialist.
d. The Prepayment Review/Recoupment Support Specialist date stamps each claim.
e. The Prepayment Review/Recoupment Support Specialist files the claim check list in chronological order by date received.
f. Claims are sorted by receipt date and provider number and stored in the prepayment file area pending review and adjudication.

2. Adjudication

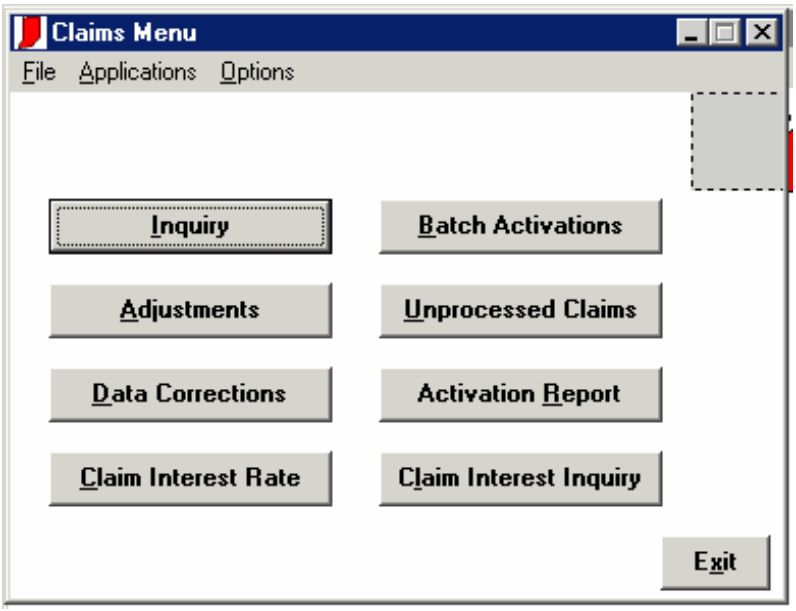
All claims are adjudicated within 60 calendar days of receipt of the source documentation from the fiscal agent. Based on the provider's prepayment review criteria and compliance with IHCP program guidelines, a payment determination is made. All claims for services that require review for medical necessity are reviewed with the medical director and/or sent to a physician consultant for determination. The steps for Indiana*AIM* claim adjudication are outlined below.

FIGURE VI – 7
MAIN MENU-PRODUCTION



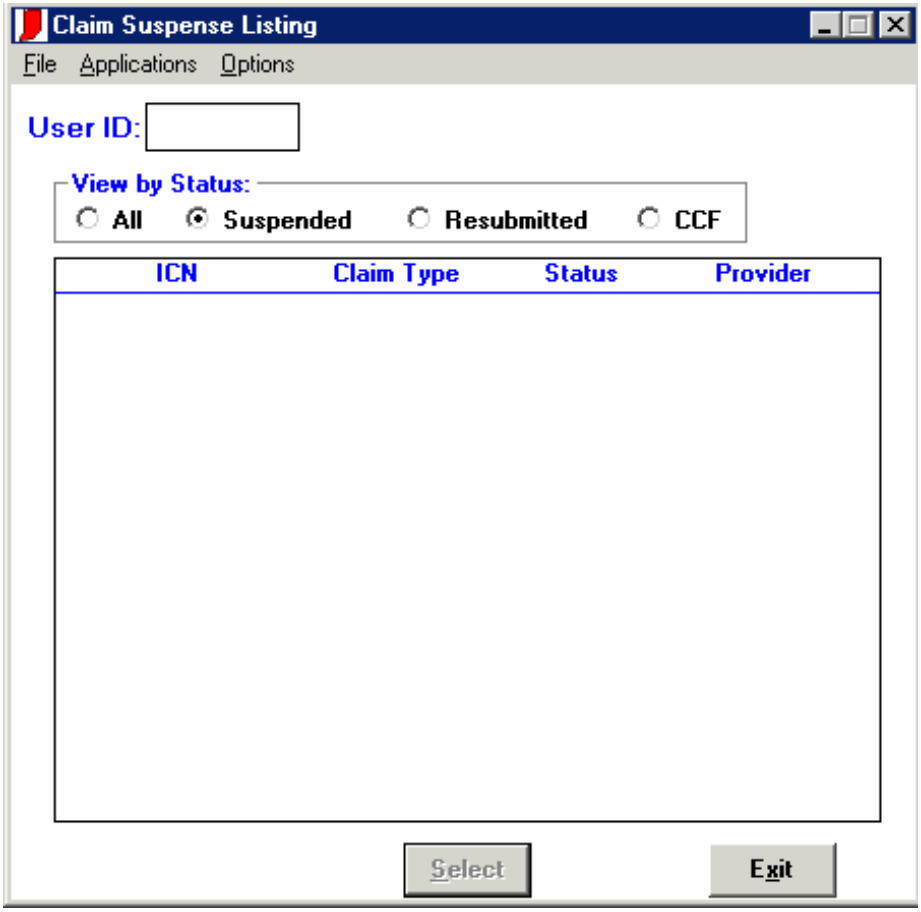
a. Select Claims to begin adjudication.

FIGURE VI – 8
CLAIMS MENU



b. Choose Data Corrections.

FIGURE VI – 9
CLAIMS SUSPENSE LISTING



c. This screen, including a list of claims suspended to this scheduler, is viewed briefly, however the system automatically bypasses to the first claim listed in the scheduler.
d. No action necessary on this screen at this time.
e. Enter the ICN of the claim to be adjudicated and select Inquire. The system will inquire "Do you want to save changes?" If no action was performed on the current claim select "No".
f. The selected claim will appear in the above format.
g. Review the Error Disp located in the lower left corner of the screen. Claims suspended for prepayment review will have an error disp of 7500 – Your Claim is Being Reviewed and/or 7509 – Rendering Provider on Prepayment Review.

FIGURE VI – 10
PHYSICIAN DATA CORRECTION

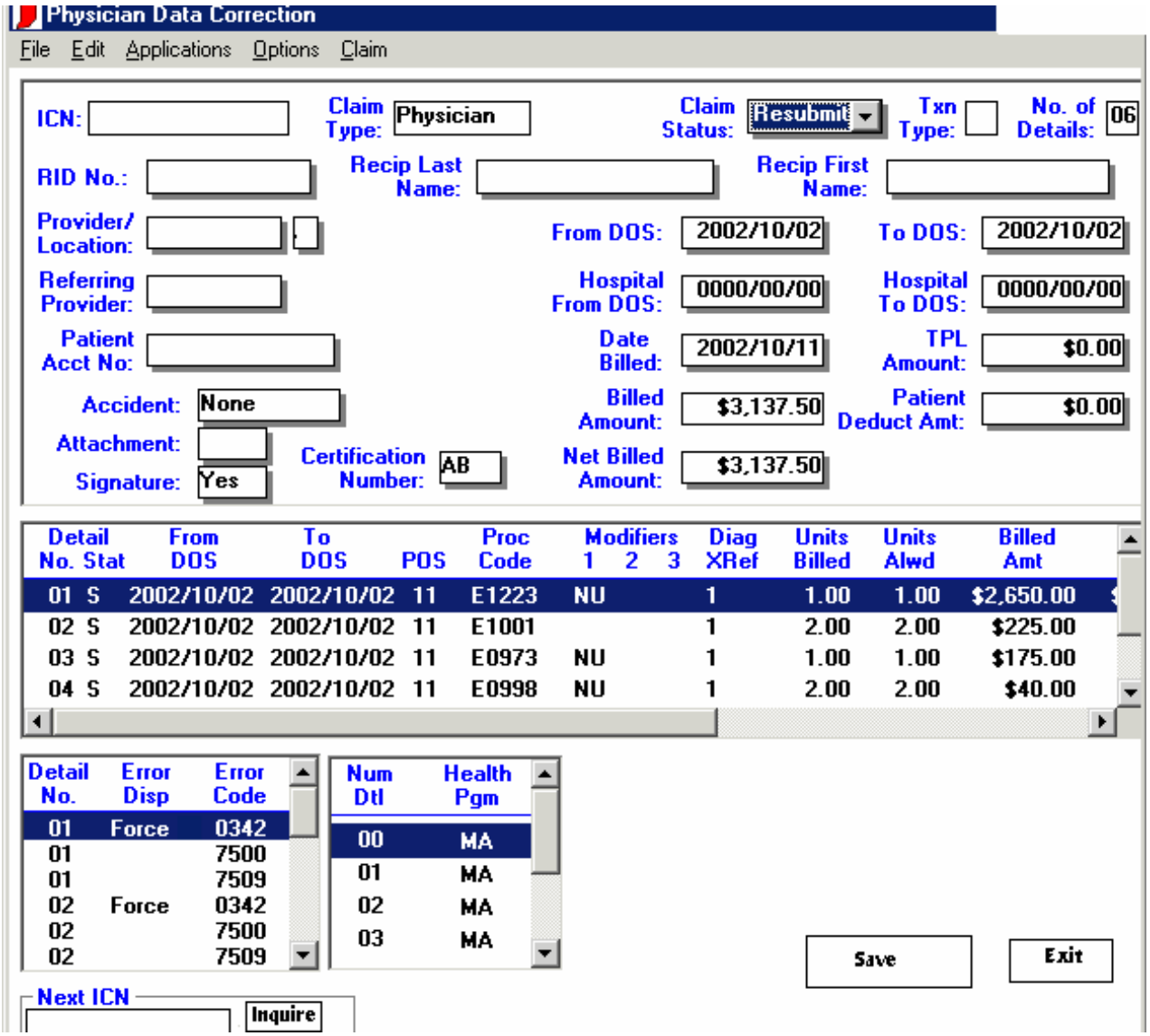
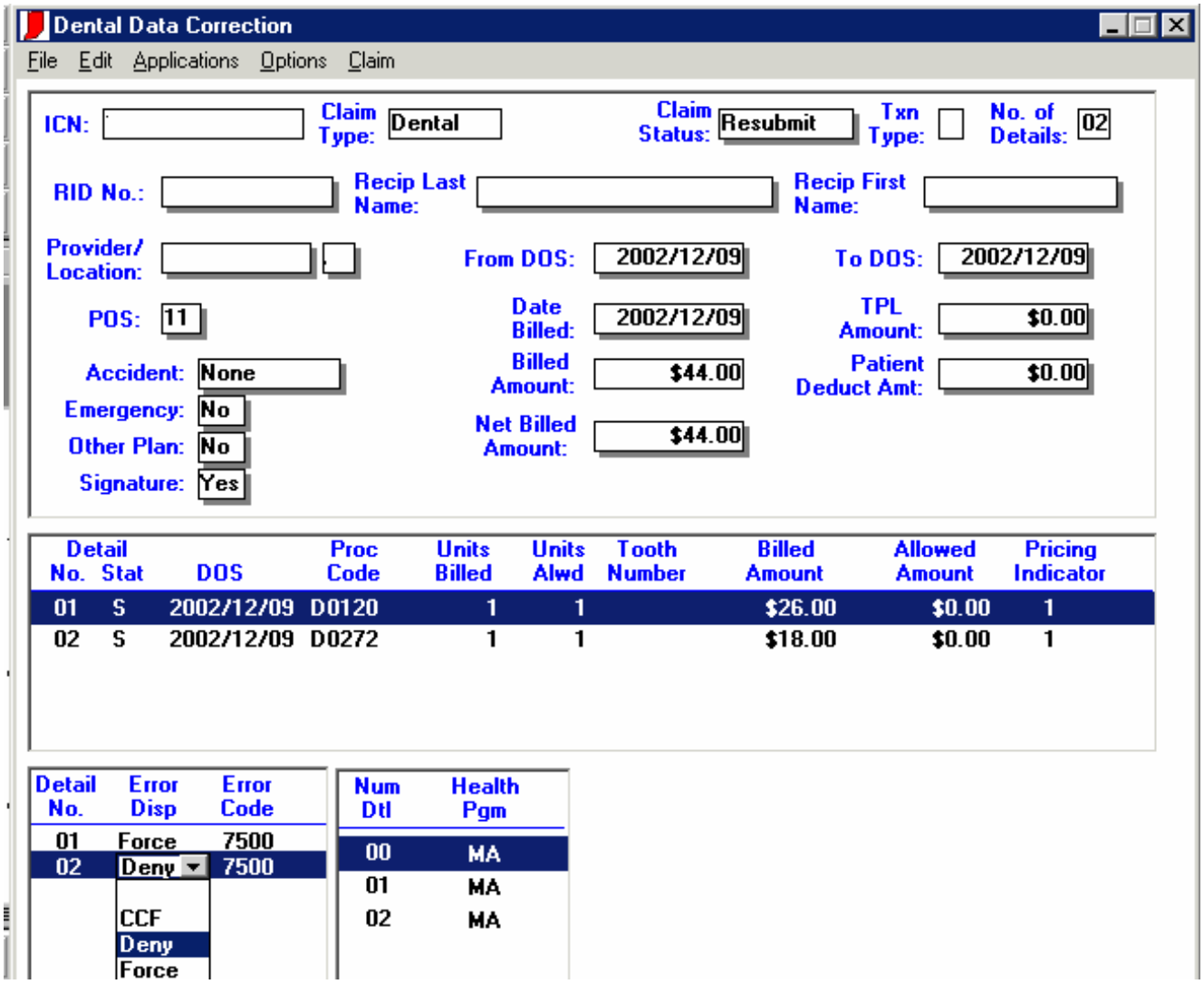
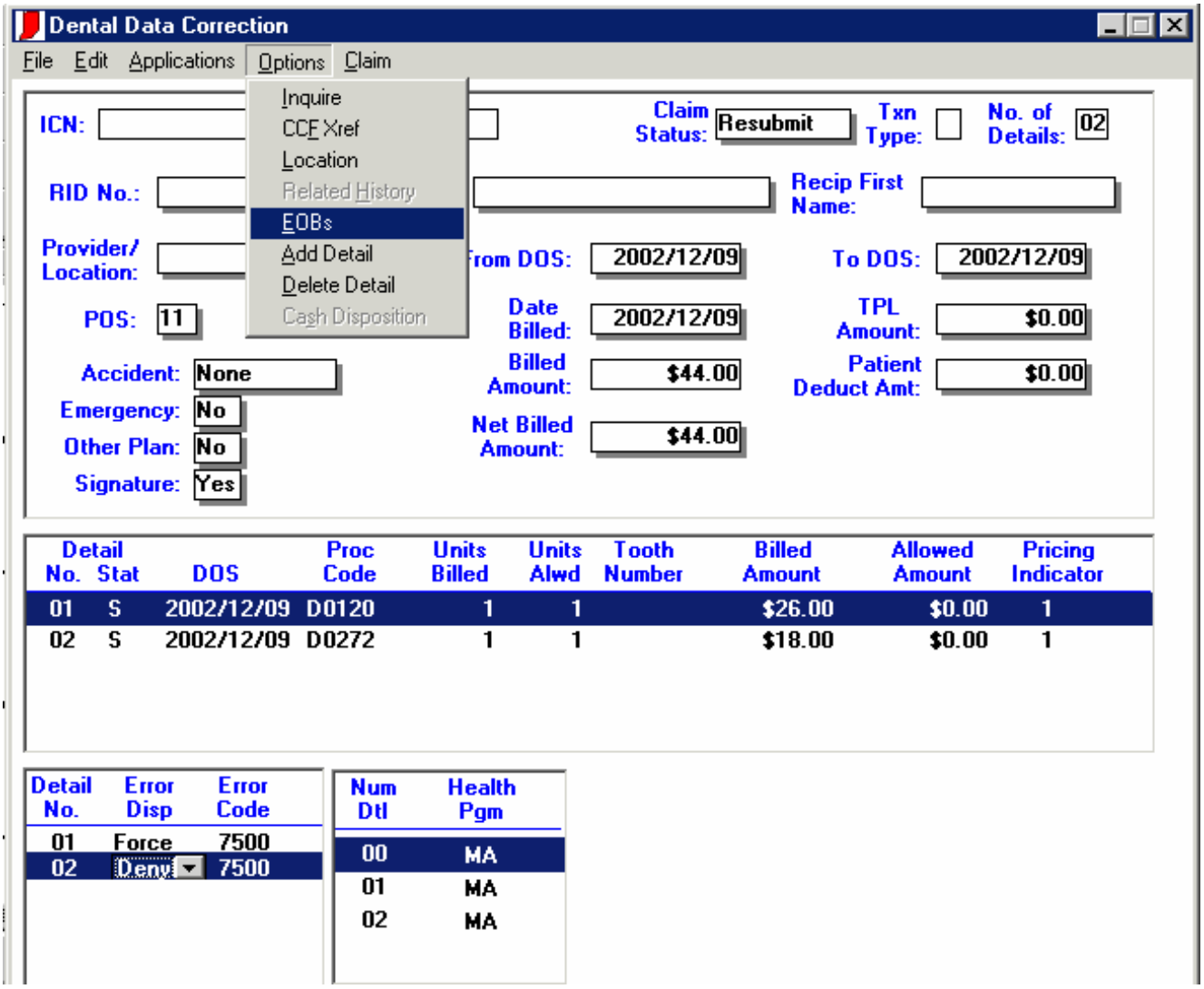


FIGURE VI – 11
DENTAL DATA CORRECTION



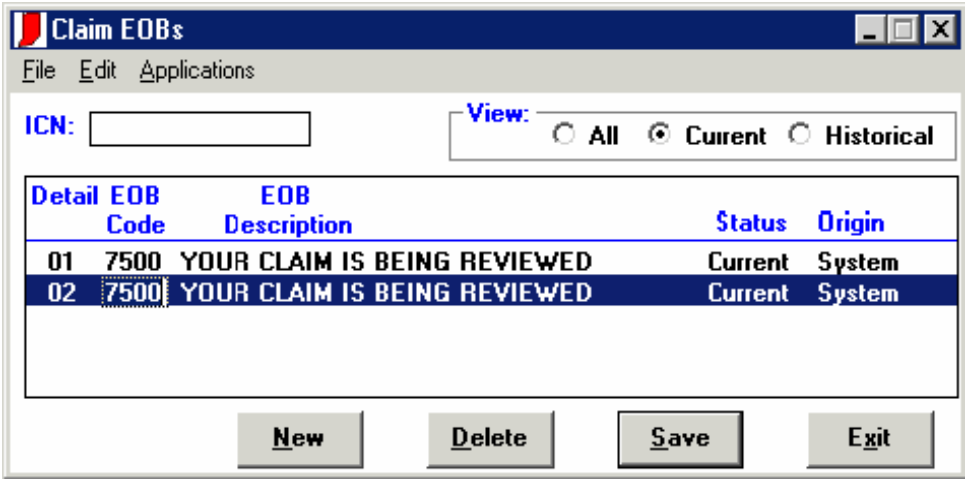
h. Place the cursor next to the error disp and left-click the left mouse button. The drop down menu shown in the example above will appear. Select the appropriate claim adjudication decision for each line item. The options are CCF, force, or deny. CCF is not utilized, as this is not a valid claim adjudication decision for prepayment review.
i. To FORCE all line items on a claim, complete the force error disp for each line item and select Save.
j. Save will prompt the next claim in the scheduler to appear.
k. If all or a portion of the claim will be DENIED proceed to the following steps.

FIGURE VI – 12
DENTAL DATA CORRECTION



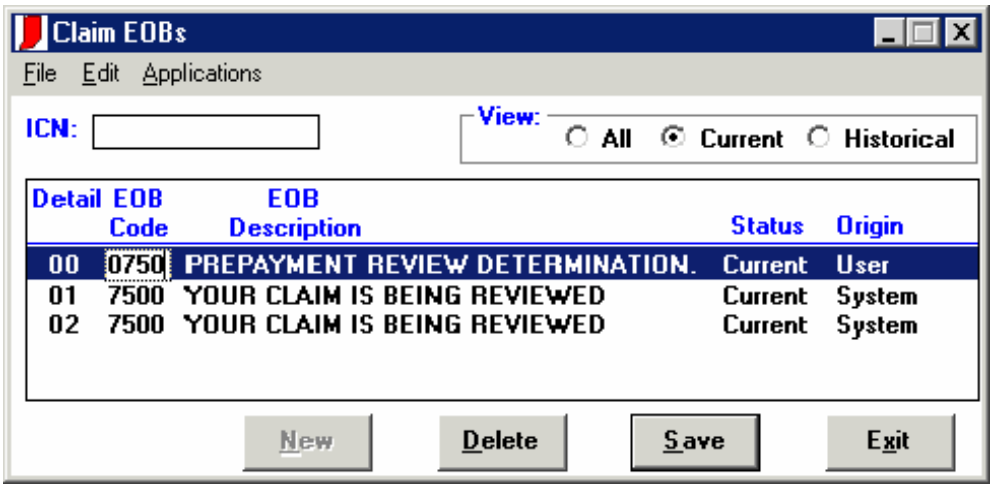
l. Once the error disp for all line items have been completed, select Options-EOBs.

FIGURE VI – 13
CLAIM EOBS



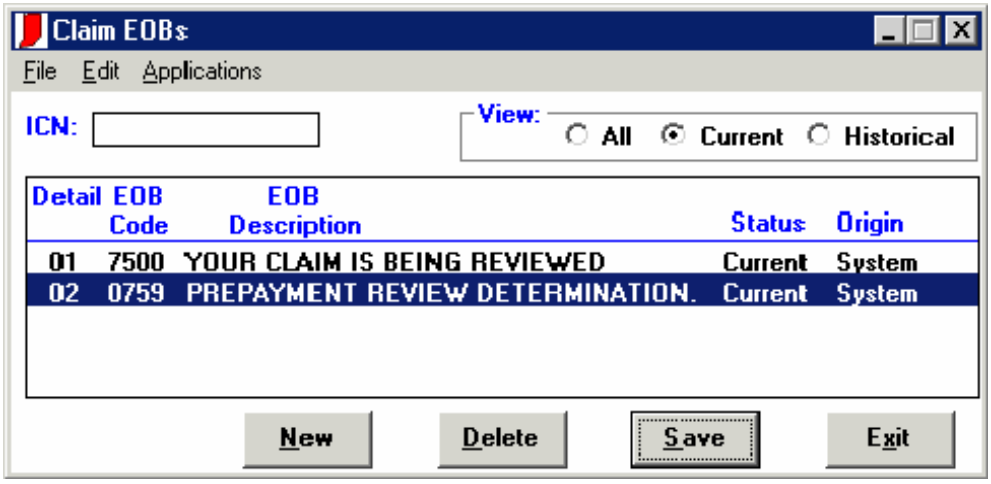
m. If the entire claim is being denied select New for a new detail line.

FIGURE VI – 14
CLAIM EOBS



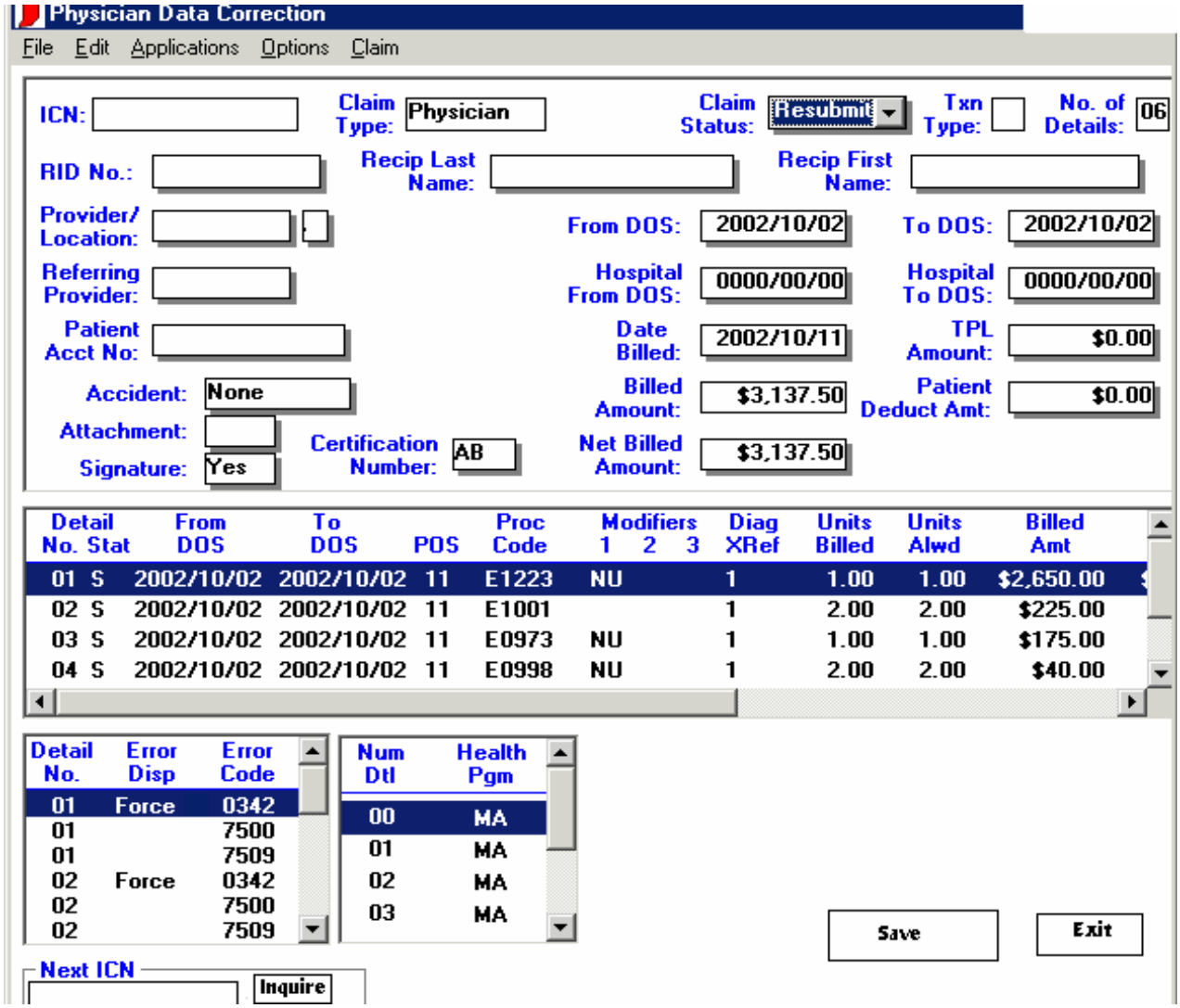
n. Type “00” in the detail field.
o. Tab to the EOB code field and select the appropriate prepayment review EOB code. (See **Exhibit VI – 3**)
p. Utilizing detail “00” on the first line item will apply the EOB description to the entire claim at the header level.
q. Select Save.
r. If only a portion of the claim is being denied, proceed through the following steps.

FIGURE VI – 15
CLAIM EOBS



s. Select the appropriate EOB code, as shown in **Figure VI – 15** for each line item.
t. Choose Save and return to the Claim Data Corrections window.

FIGURE VI – 16
PHYSICIAN DATA CORRECTION



u. Select Save to complete claim adjudication.

3. Provider Maintenance

Maintenance of a provider on prepayment review requires ongoing interaction with the provider. This interaction may involve verbal education via the telephone or written direction. Management staff may be involved in this correspondence based upon the nature of the situation. If the above resolutions are not effective in resolving the provider issue, an on-site educational visit may be necessary. This may require coordination through the fiscal agent with the provider representative assigned to the provider. If a provider is not satisfied with the above resolutions, OMPP is consulted regarding further steps. All

provider complaints are responded to and resolved within ten (10) days of complaint receipt, with copies of provider's complaint and SUR response routinely forwarded to the State.

C. Compliance Review

Compliance reviews are completed to assess provider adherence to IHCP program guidelines during the prepayment review period. These reviews will occur monthly or more frequently, as needed. Monthly claim denial reports are generated for each provider actively submitting claims for prepayment review. These reports provide educational information including specific reasons for claim denial on a claim by claim basis. Based on the monthly report statistics, the Prepayment Review Coordinator/Reviewer may recommend continuation or termination of prepayment review.

D. Termination of Prepayment Review

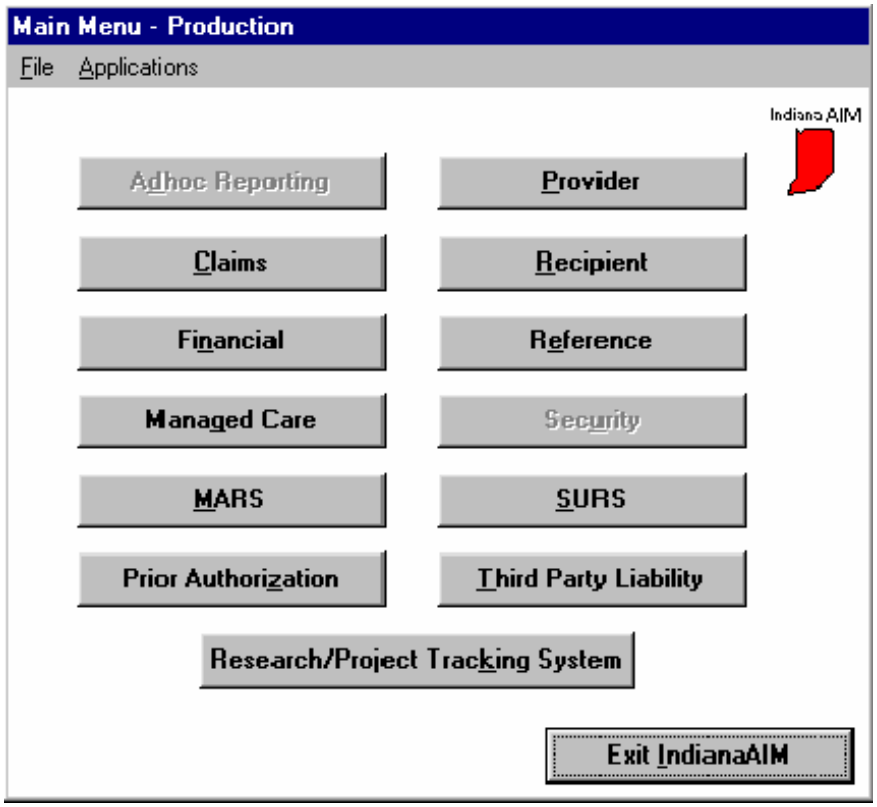
The determination to terminate prepayment review is based on the observation and documentation of resolution of problems identified in the off-site review and/or audit findings letter which led to the initiation of prepayment review as well as provider compliance with IHCP guidelines while on prepayment review. The recommendation to discontinue the review will be made by the Prepayment Review Coordinator/Reviewer.

If a provider discontinues claims submission, a quarterly review of provider enrollment status and claim status will be performed. This review will include verification of appropriate claims suspension to Location 30 and identification of any related provider numbers and/or tax identification numbers to ensure the provider has not circumvented the prepayment review process.

The steps to terminate a provider from prepayment review are outlined below.

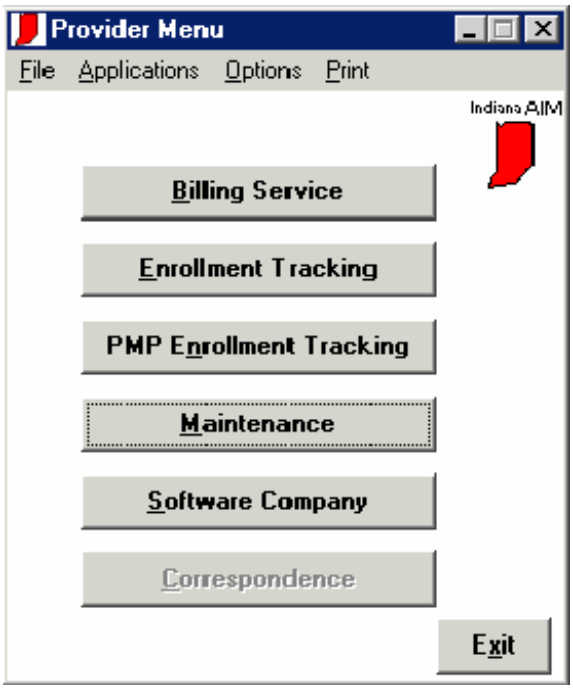
1. A prepayment review termination letter is sent to the provider specifying the date of termination. See **EXHIBIT VI – 4**.
2. On the termination date, the following steps will be completed in Indiana*AIM*.

FIGURE VI – 17
MAIN MENU-PRODUCTION



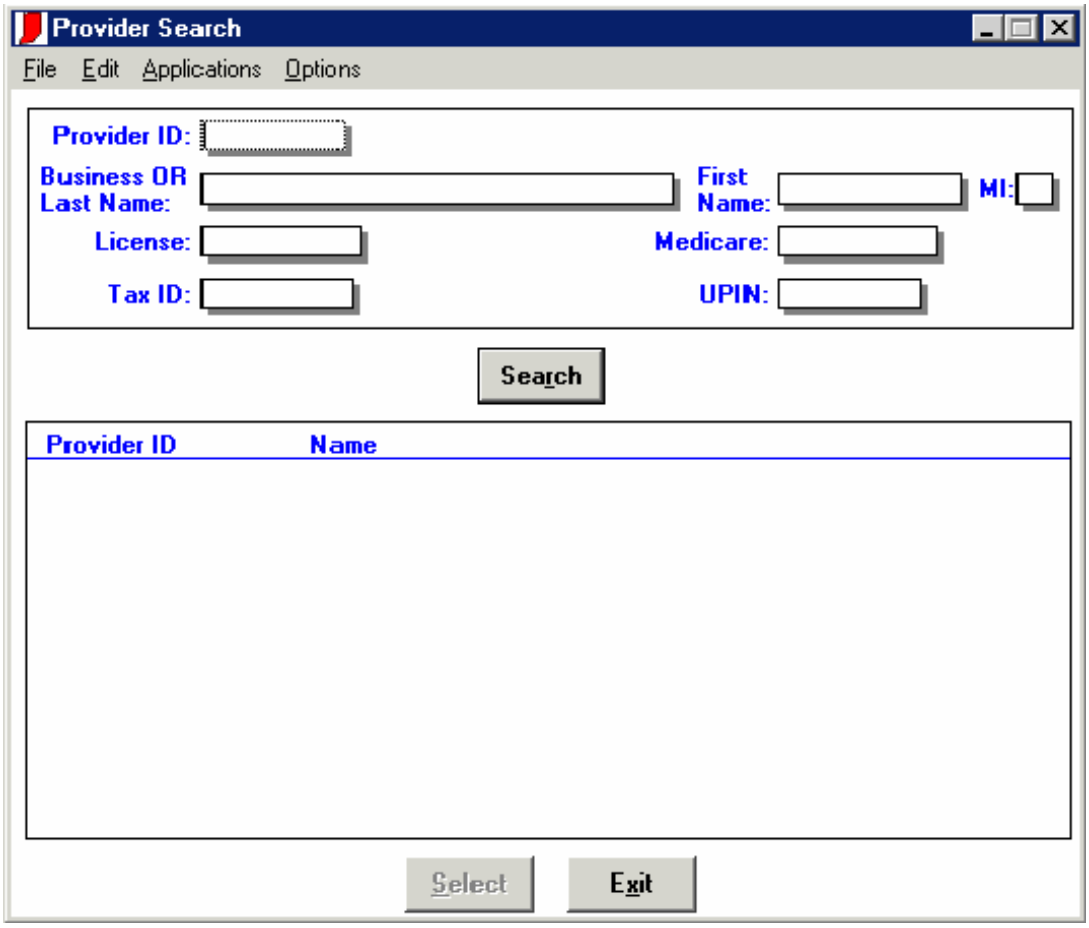
a. Select Provider to begin provider termination of prepayment review.

FIGURE VI – 18
PROVIDER MENU



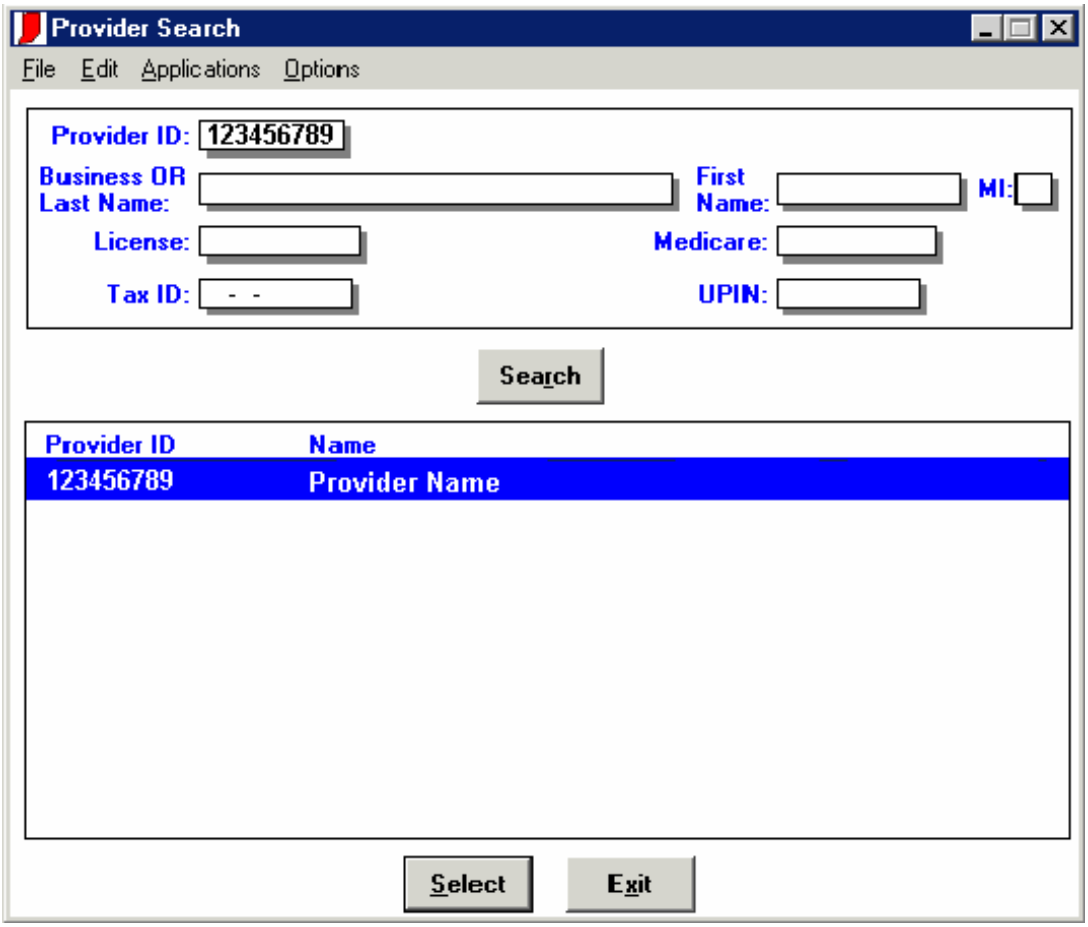
b. Choose Maintenance to select the provider for termination.

FIGURE VI – 19
PROVIDER SEARCH



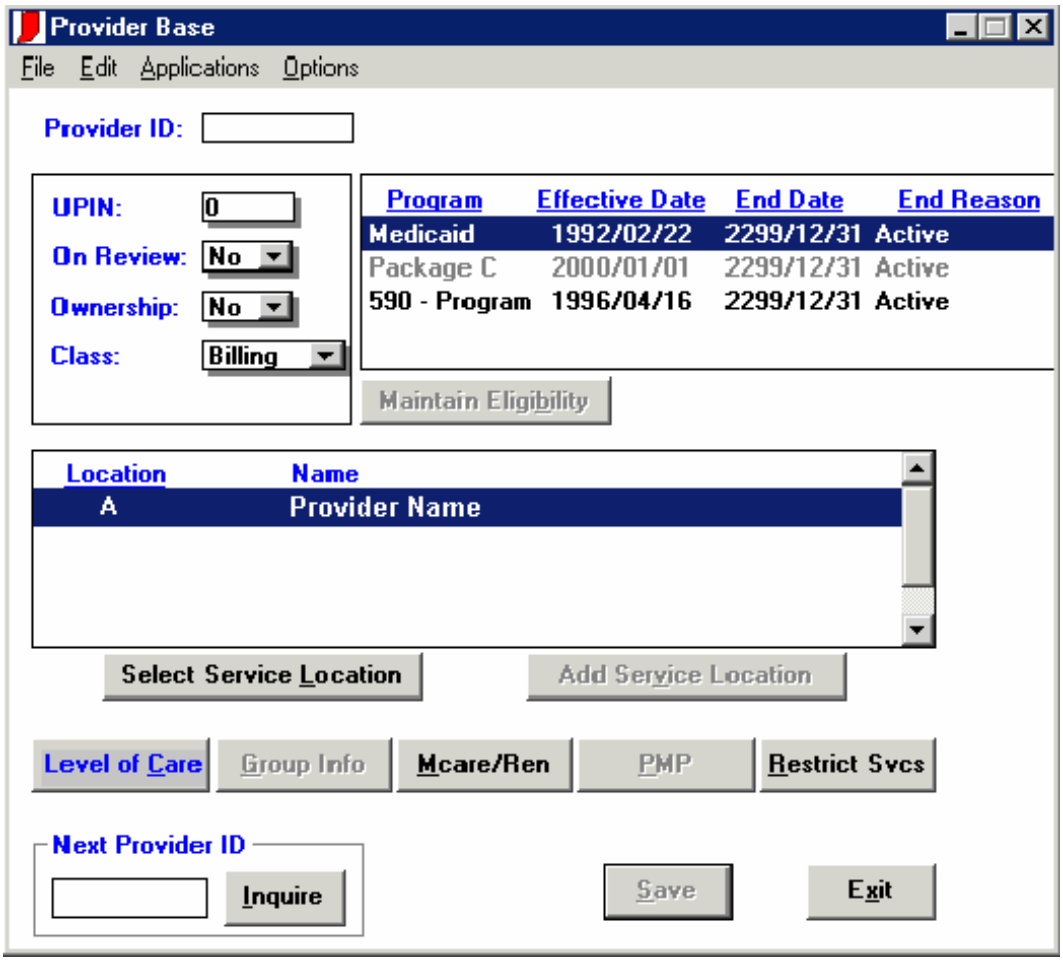
c. Enter the provider number in provider ID box recommended for termination of prepayment review.

FIGURE VI – 20
PROVIDER SEARCH



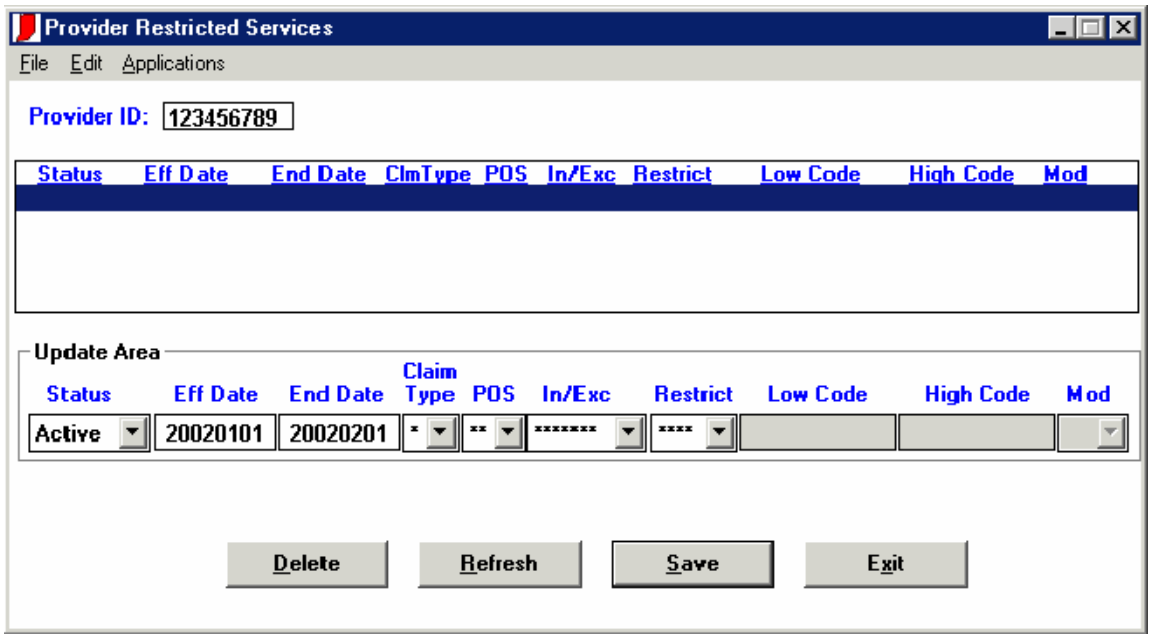
d. Verify provider information.
e. Choose Select.

FIGURE VI – 21
PROVIDER BASE



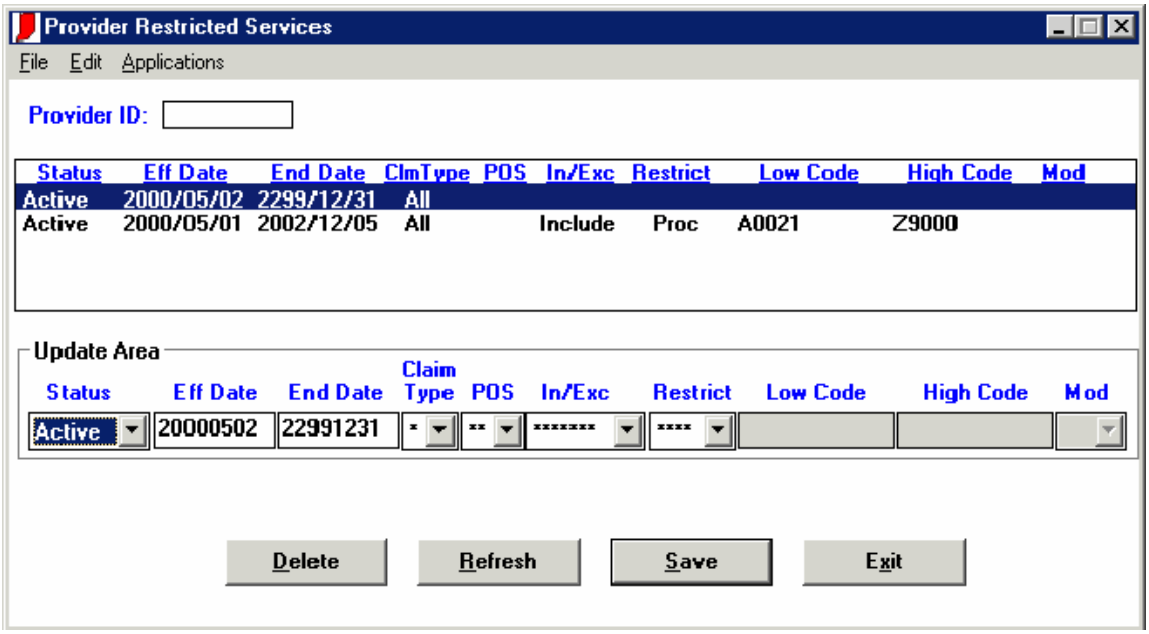
f. Select Restrict Services.

FIGURE VI – 22
PROVIDER RESTRICTED SERVICES



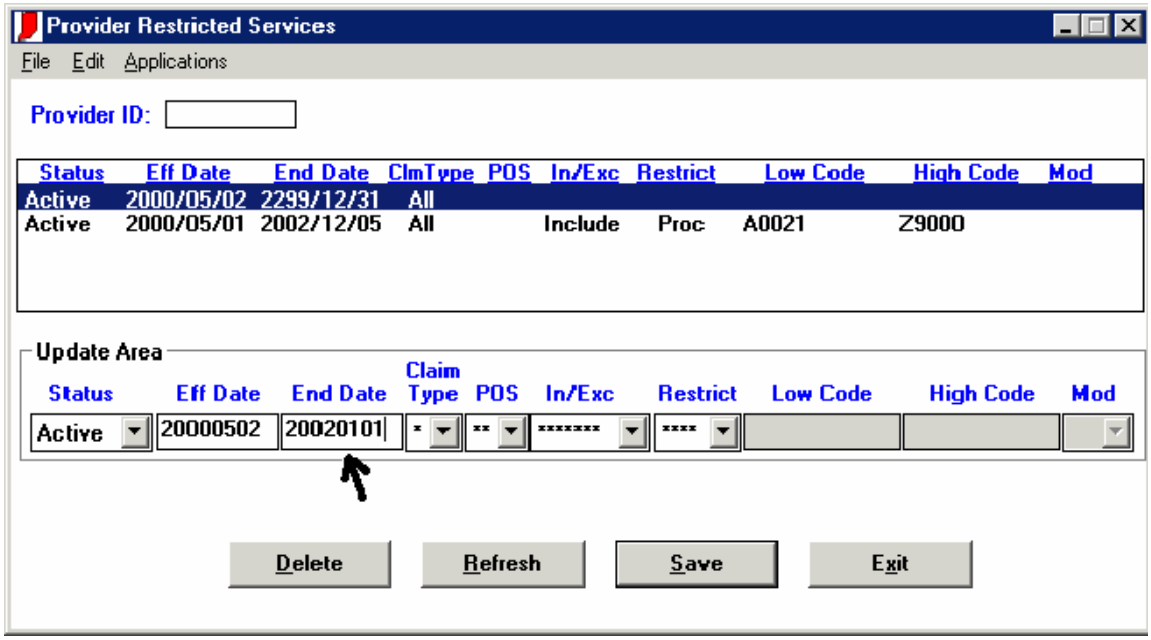
g. Select the line item to be updated for termination.

FIGURE VI – 23
PROVIDER RESTRICTED SERVICES



h. The line item will appear in the update area on the lower portion of the screen.

FIGURE VI – 24
PROVIDER RESTRICTED SERVICES



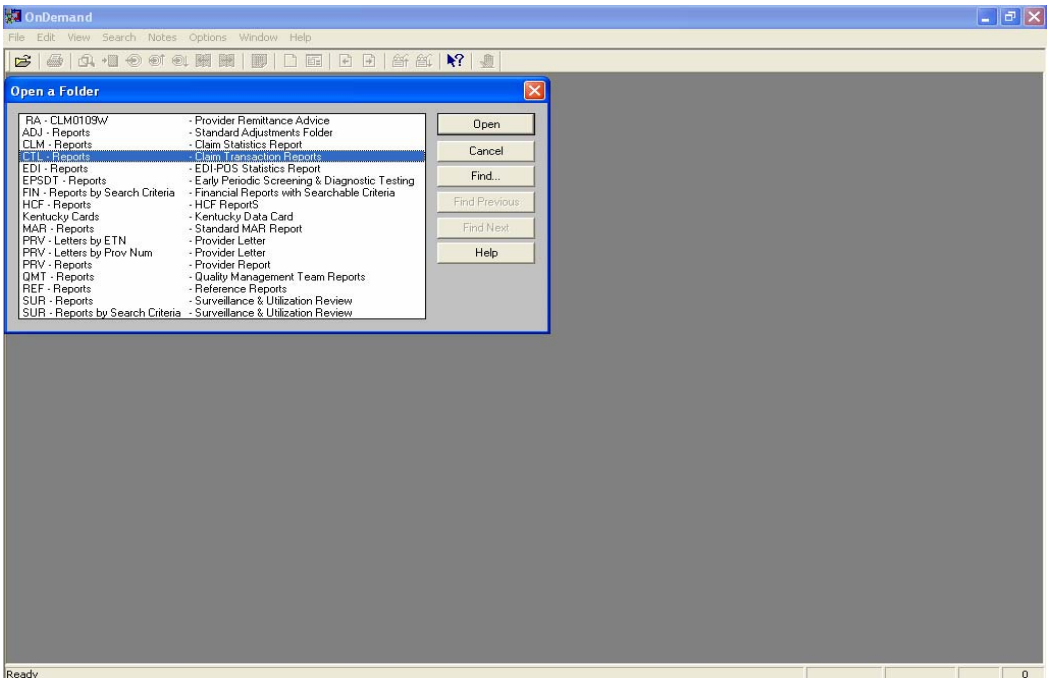
i. Change the End Date field to the recommended termination date. If there is more than one line item for the restriction, each line with a termination date must be updated.
j. Select Save.
k. Print this screen from Indiana*AIM* once the termination date has been completed and file this copy in the prepayment review file.
l. Notify the fiscal agent's Provider Enrollment Supervisor to change the On Review field in the Provider Base screen of Indiana*AIM* to No.
m. Update the SURS database with the above information.
n. The prepayment review provider file is now considered closed.
o. The provider will be monitored for a follow-up review.

E. Prepayment Review-Monitoring Claim Review

1. Aged Claims Report CTL-130-D

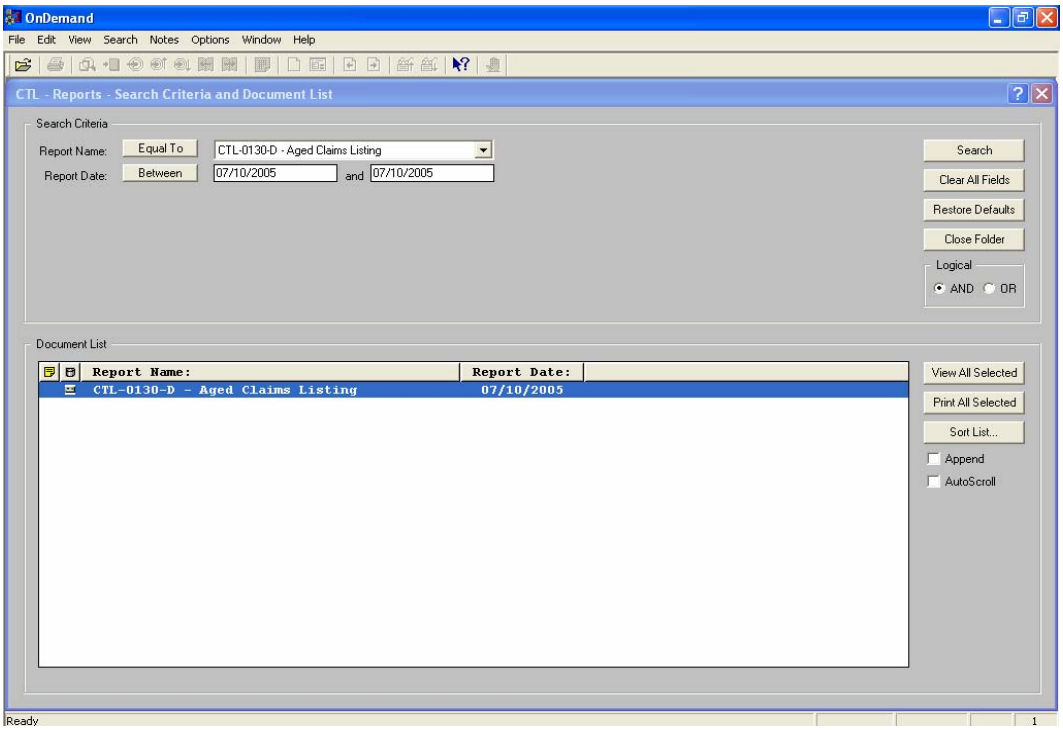
This report is generated daily and indicates claims suspended to Location 22 (reviewed by Prior Authorization) and 30 (reviewed by Prepayment Review). This report lists the ICN, RID number, provider number, location code, and the claim suspense date. The report will include only those claims with suspense dates older than twenty days. This report is monitored for aging claims in Location 30. The number in the ELSP column (**Figure VI – 27**) should not exceed 90 days to remain in compliance with contract requirements. This report does not include any claim adjustments that may be listed in the scheduler.

FIGURE VI – 25
ON DEMAND



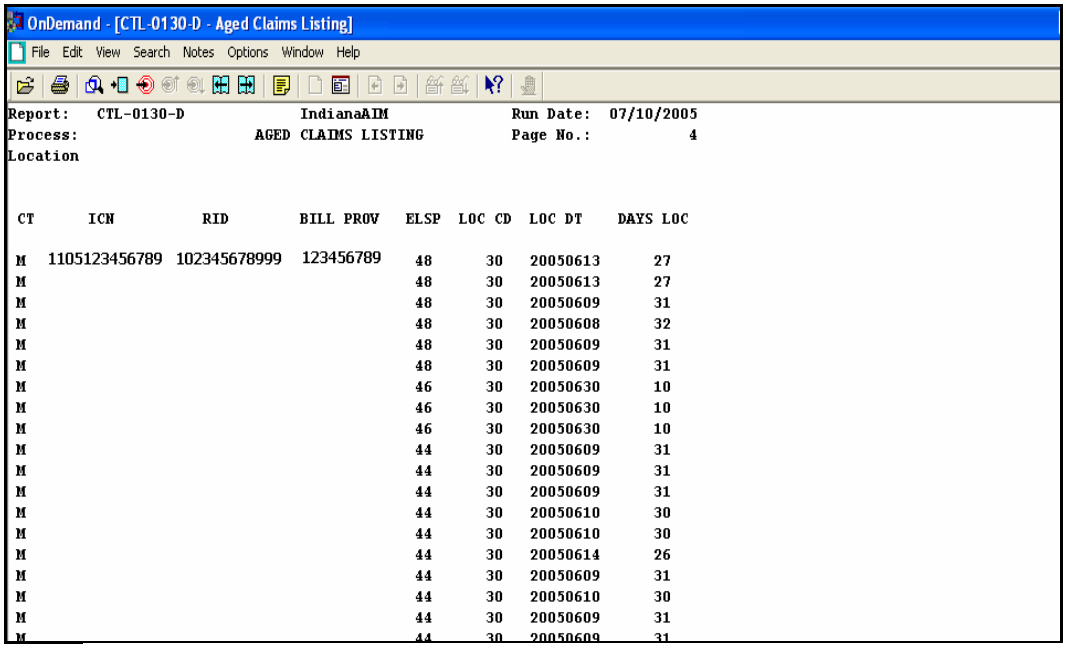
a. To view this report, access On Demand.
b. Select CTL-Reports (Claims Transaction Report) from the list of folders and click open.

FIGURE VI – 26
CTL-REPORTS-SEARCH CRITERIA AND DOCUMENT LIST



c. Select CTL-0130-D – Aged Claims Listing and enter yesterday's date in the Report Date fields.
d. Select Search.
e. When the segment containing the desired report appears, choose View All Selected.

FIGURE VI – 27
ON DEMAND [CTL-0130-D-AGED CLAIMS LISTING]



Report: CTL-0130-D IndianaAIM Run Date: 07/10/2005
Process: AGED CLAIMS LISTING Page No.: 4
Location

CT	ICN	RID	BILL PROV	ELSP	LOC CD	LOC DT	DAYS LOC
M	1105123456789	102345678999	123456789	48	30	20050613	27
M				48	30	20050613	27
M				48	30	20050609	31
M				48	30	20050608	32
M				48	30	20050609	31
M				48	30	20050609	31
M				46	30	20050630	10
M				46	30	20050630	10
M				46	30	20050630	10
M				44	30	20050609	31
M				44	30	20050609	31
M				44	30	20050609	31
M				44	30	20050610	30
M				44	30	20050610	30
M				44	30	20050614	26
M				44	30	20050609	31
M				44	30	20050610	30
M				44	30	20050609	31
M				44	30	20050609	31

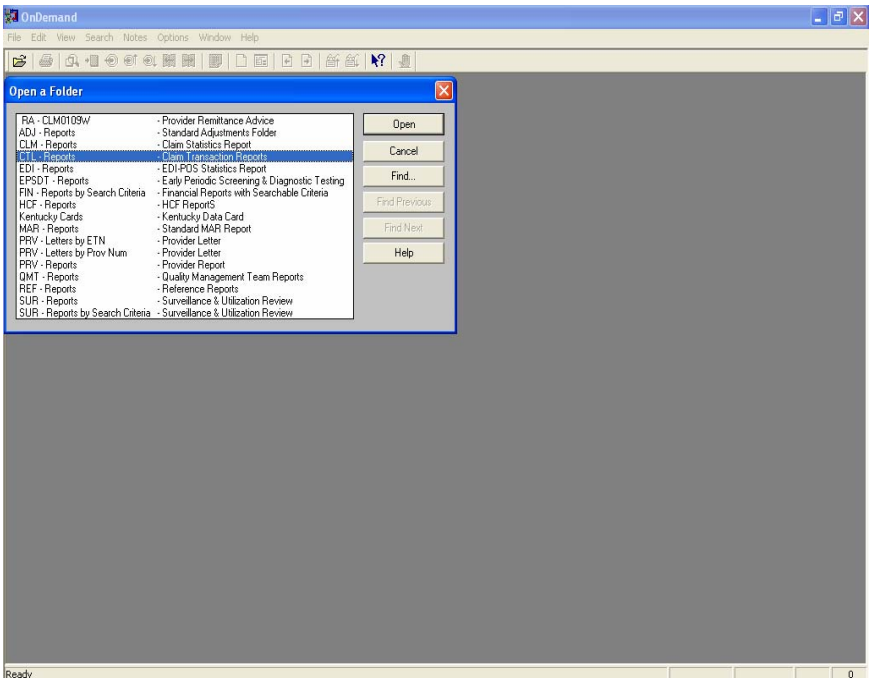
f. Print the report for review and resolution of aging claims.

2. Medical & SURS Suspense Report CTL-160-D

This report identifies claims suspended the previous day for Locations 22, 30 and 31. The fiscal agent utilizes this report to identify which claims require documentation be forwarded to HCE. This is utilized by prepayment review as a tool to monitor appropriate receipt of claim documentation from the fiscal agent.

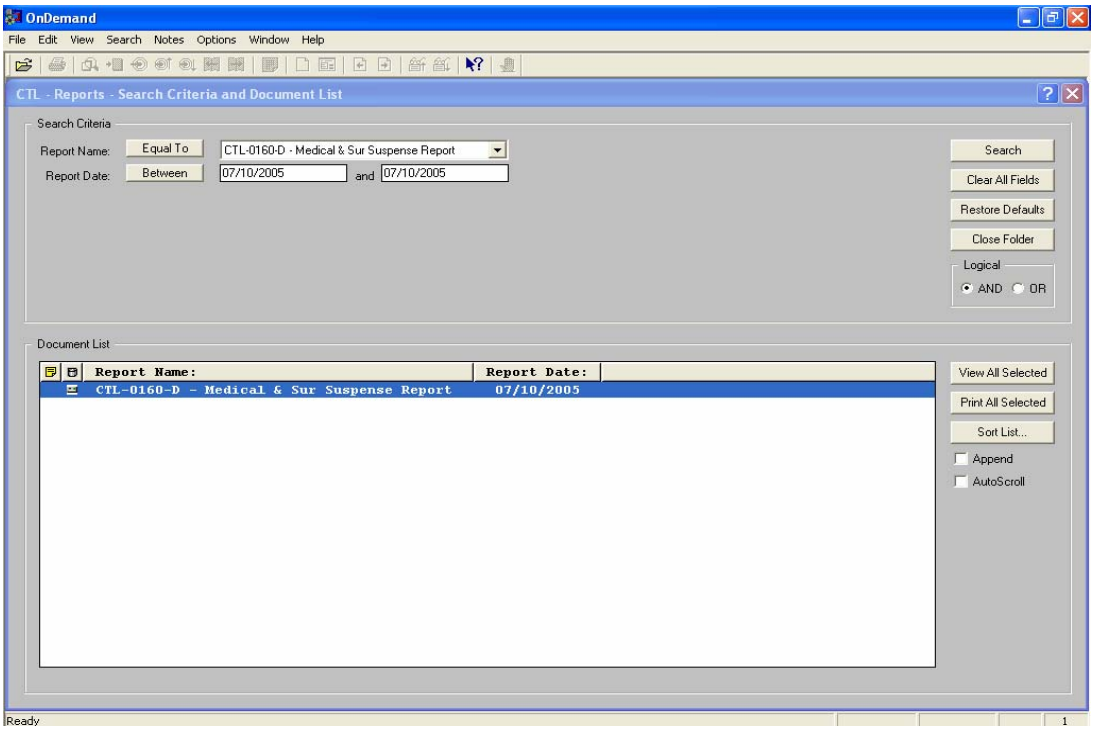
a. To view this report, access On Demand.

FIGURE VI – 28
ON DEMAND



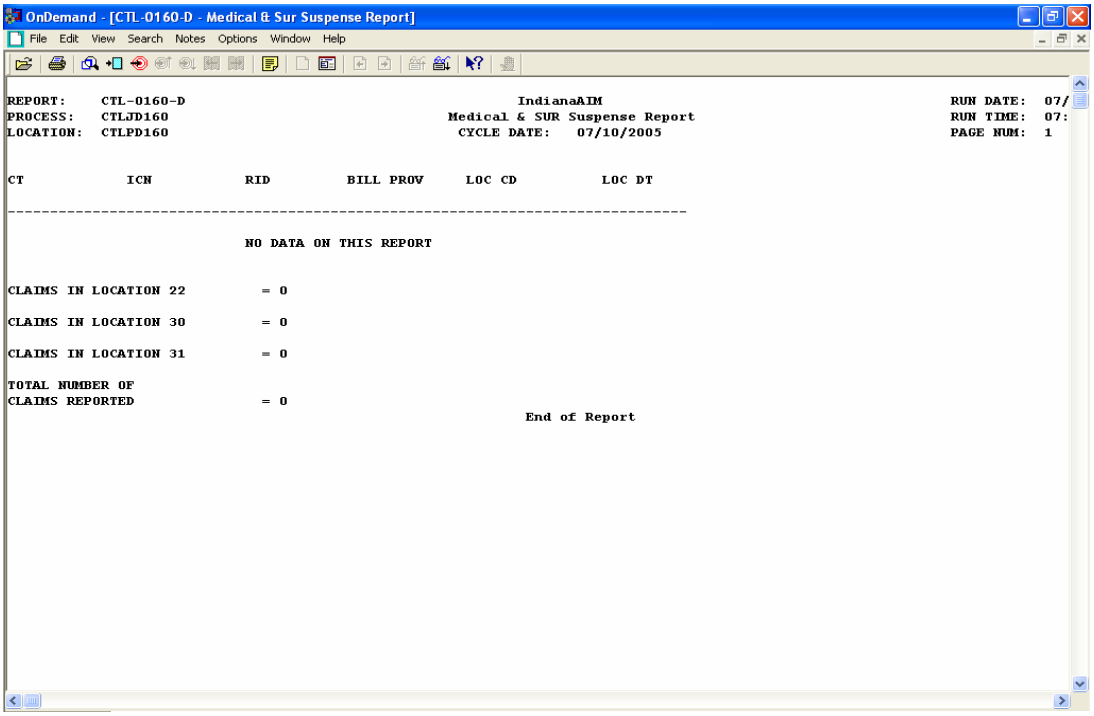
b. Select CTL-Reports (Claims Transaction Report) from the list of folders and open.

FIGURE VI – 29
CTL-REPORTS-SEARCH CRITERIA AND DOCUMENT LIST



c. Select CTL-0160-D-Medical & SURS Suspense Report and enter yesterday's date the Report Date fields.
d. Select Search.
e. When the segment containing the desired report appears, choose View All Selected.

FIGURE VI – 30
ON DEMAND – [CTL-0160-D-MEDICAL & SUR SUSPENSE REPORT]



f. Print the report for verification purposes.

3. Other Reports

A summarization of prepayment review accomplishments, activities, and current balances is submitted for inclusion in the SUR quarterly and annual reports. Ad hoc reports are compiled as requests are received.

EXHIBIT VI – 1
NOTIFICATION OF PREPAYMENT REVIEW

INSERT CURRENT DATE

INSERT PROVIDER NAME
INSERT PROVIDER ADDRESS
INSERT CITY, STATE, ZIP CODE

Provider Number: INSERT PROVIDER #

Certified Mail Number: INSERT CERTIFIED #

RE: Prepayment Review Notification

Dear INSERT PROVIDER NAME:

This letter serves as notification that pursuant to 405 IAC 1-1-6(f), Health Care Excel will institute prepayment review of all of the services billed on your Indiana Health Coverage Programs (IHCP) claims as defined by the enclosed Prepayment Review Criteria form. INSERT REASON FOR PREPAYMENT REVIEW. Charges for services that do not meet IHCP guidelines for reimbursement will be subject to denial.

Prepayment review will be implemented on INSERT START DATE for those claims with dates of service beginning INSERT RETRO DATE that has not been paid to date. **Prepayment review will be instituted for a minimum of six months and remain in effect until the services billed are in compliance with the IHCP guidelines as determined by the Indiana Family and Social Services Administration.** It is our intent to maintain open lines of communication throughout the course of prepayment review, to assist you in the development of billing practices that are compliant with the IHCP guidelines.

During this period, the **manual submission** of claims should be submitted to**:**

Electronic Data Systems (EDS) INSERT TYPE OF CLAIM
P.O. Box INSERT ADDRESS FOR TYPE OF CLAIM
Indianapolis, IN 46207- INSERT ZIP CODE EXTENSION

For **electronic submissions with paper attachments,** please refer to the IHCP Provider Manual, Chapter 8 for further instructions.

For each claim undergoing prepayment review, the following additional documentation will be required. Please make sure that all documentation sent is photocopied as **single-sided** copies.

1. INSERT DOCUMENTATION REQUIREMENTS FOR SPECIALTY.
2. Prior authorization numbers for the date of service billed (if applicable).
3. Prior authorization request form for the date of service (if applicable).

3. Proof of third party payment or denial (if applicable).
4. Any other information deemed relevant to support services billed.

The documentation requirements for this process have been explained above and failure to comply will result in denied claims. All claims should be forwarded to EDS, who will process and send the claims to HCE for review of supporting documentation and adjudication. The enclosed Health Care Excel Prepayment Review Criteria form outlines the specific requirements established under prepayment review for your claims and should be signed and dated to signify your understanding. The completed form should be returned to us; however, prepayment review will begin as scheduled regardless of receipt of the form. We recommend that you maintain a copy of the completed form for your records and future reference.

We appreciate and value your participation in the Indiana Health Coverage Programs. Should you have any questions regarding prepayment review, you may contact the Prepayment Review Coordinator by calling (317) 347-4500, extension 224.

Sincerely,

_____

INSERT REVIEWER NAME
Reviewer, Surveillance and Utilization Review

_____

INSERT SUPERVISOR NAME
Audit Supervisor, Surveillance and Utilization Review

_____

INSERT DIRECTOR NAME
Director, Surveillance and Utilization Review

Enclosures

c: INSERT NAME, OMPP
INSERT NAME, FSSA Legal Counsel
Medicaid Fraud Control Unit
Provider Representative, EDS
Prepayment Review Coordinator, HCE

EXHIBIT VI – 2
HEALTH CARE EXCEL PREPAYMENT REVIEW CRITERIA

Date: INSERT CURRENT DATE

Provider Name: INSERT PROVIDER NAME

Provider Number: INSERT PROVIDER #

Prepayment Review Implementation Date: INSERT START DATE

Review Criteria: Prepayment review will apply to all codes billed to Indiana Health Coverage Programs (IHCP) for those claims with dates of service beginning INSERT RETRO DATE that have not been paid to date.

During this period, **manual submission** of claims should be submitted to**:**

Electronic Data Systems (EDS) INSERT TYPE OF CLAIM
INSERT ADDRESS FOR TYPE OF CLAIM
Indianapolis, IN 46207- INSERT ZIP CODE EXTENSION

For **electronic submissions with paper attachments**, please refer to the IHCP Provider Manual, Chapter 8 for further instructions.

For each claim undergoing review, the following additional documentation will be required. Please make sure that all documentation sent is photocopied as **single-sided** copies.

1. INSERT DOCUMENTATION REQUIREMENTS FOR SPECIALTY.
2. Prior authorization numbers for the date of service billed (if applicable).
3. Prior authorization request form for the date of service billed (if applicable).
4. Proof of third party payment or denial (if applicable).
5. Any other information deemed relevant to support services billed.

This date I have received a copy of the above criteria to be followed when submitting claims to IHCP for payment while on prepayment review. I understand that failure to comply will result in denied claims.

Continued non-compliance with IHCP prepayment guidelines could result in possible suspension from the IHCP program and/or referral to the Indiana Medicaid Fraud Control Unit (IMFCU.)

Please sign and return to: Health Care Excel
Attn: Prepayment Review
P.O. Box 531700
Indianapolis, IN 46253-1700

We recommend that you maintain a copy of this form for your records and future reference.

EXHIBIT VI – 2
HEALTH CARE EXCEL PREPAYMENT REVIEW CRITERIA (Continued)

Failure to sign and return this document to Health Care Excel Prepayment Review does not alleviate the current decision that has been made for the claim(s) adjudication.

_____ _____

INSERT REVIEWER NAME
Reviewer, Surveillance and Utilization Review

Provider Signature

_____ Date ___/___/___

INSERT SUPERVISOR NAME
Audit Supervisor, Surveillance and Utilization Review

_____

INSERT DIRECTOR NAME
Director, Surveillance and Utilization Review

EXHIBIT VI – 3
PREPAYMENT REVIEW EOB CODES AND DESCRIPTIONS

EOB Code	Description
0750	Prepayment review determination. Documentation, as required by your prepayment review guidelines criteria, does not support the level of service billed.
0751	Prepayment review determination. Documentation submitted does not contain clinical sign/symptoms to justify medical necessity of this service.
0759	Prepayment review determination. Required documentation is not included.

EXHIBIT VI – 4
PROVIDER NOTICE – TERMINATION OF PREPAYMENT REVIEW

Date

Provider Name
Provider Address

Certified Mail Receipt Number:

Provider #

Dear Provider:

Effective **Date** prepayment review of your Indiana Health Coverage Programs claims **was/will be** terminated. You will no longer be required to submit documentation with your claims with dates of service after **Date**.

The EDS Client Services Unit or your provider representative will continue to be available to educate and assist you with questions regarding appropriate billing practices.

We will perform a follow-up review within the next twelve months to determine your continued compliance with the Indiana Health Coverage Programs guidelines. If at that time it is determined that a pattern of aberrant billing has reoccurred, you may again be subject to prepayment review of your claims.

We appreciate your participation in and cooperation with the Indiana Health Coverage Programs.

Sincerely,

_____

Coordinator Name
Prepayment Review Coordinator

EXHIBIT VI – 4
PROVIDER NOTICE – TERMINATION OF PREPAYMENT REVIEW (Continued)

_____
Supervisor Name
Audit Supervisor, Surveillance and Utilization Review

_____
Director Name
Director, Surveillance and Utilization Review

Enclosures

c: OMPP Representative, OMPP
OMPP Representative, OMPP Legal Counsel
Provider Representative, EDS
Medicaid Fraud Control Unit
Prepayment Review Coordinator
Program Integrity Specialist